KAMALA D. HARRIS
Attorney General of California
DIANN SOKOLOFF
Supervising Deputy Attorney General
SHANA A. BAGLEY
Deputy Attorney General
State Bar No. 169423
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2129
Facsimile: (510) 622-2270
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TOMMIE BRADEN** **7011 Sunne Lane, #337** **Walnut Creek, CA 94597** **Registered Nurse License No. 780566** Respondent.	Case No. 2013-452 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 30, 2010, the Board of Registered Nursing issued Registered Nurse License Number 780566 to Tommie Braden (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on December 31, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 118, subdivision (b), provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

8. Code section 2761 states, in part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. . . .

9. Code section 2762 states, in part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

10. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

11. Code section 4059, subdivision (a), provides, in pertinent part, that "[n]o person shall furnish any dangerous drug, except upon the prescription of a physician . . ."

12. Code section 4060 provides, in pertinent part that "[n]o person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician . . ."

13. Code section 4140 provides that: "No person shall possess or have under his or her control any hypodermic needle or syringe except when acquired in accordance with this article."

14. Health and Safety Code section 11173, subdivision (a), provides:

> No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact.

15. Health and Safety Code section 11190, subdivision (a), provides:

> Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:
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> (1) The name and address of the patient.
>
> (2) The date.
>
> (3) The character, including the name and strength, and quantity of controlled substances involved.

COST RECOVERY

16. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUGS

17. Fentanyl is a controlled substance as defined in Schedule II, Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug pursuant to Code section 4022. It is a highly potent opiate used for pain relief.

18. Lorazepam is the generic name for the trade drug Ativan. It is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057, subdivision (d)(16), and a dangerous drug pursuant to Code section 4022. It is an anti-anxiety agent.

19. Oxycodone is the generic name for the brand named drug Percocet. It is a controlled substance as defined in Schedule II, Health and Safety Code section 11055,

subdivision (b)(1)(M), and a dangerous drug as defined in section 4022. It is a synthetic non-opiate derivative used extensively in the treatment of mild to moderate pain and fever.

FACTUAL STATEMENT

20. From April 4, through July 3, 2011, Respondent worked as a traveling registered nurse at San Francisco General Hospital located in San Francisco, California. On or about July 3, 2011, San Francisco General Hospital terminated Respondent.

21. During the course of his employment at San Francisco General Hospital, Respondent committed the following acts and omissions:

a. PATIENT LF[1]:

i. On or about April 24, 2011, Patient LF's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as needed for pain.

ii. On or about April 27, 2011, at 0545 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system[2] to administer to Patient LF. Respondent charted the administration of 50 mcg of the medication but charted the wastage of 75 mcg. Respondent charted that he administered 25 mcg more than what he removed from Omnicell.

b. PATIENT ML

i. On or about May 30, 2011, Patient ML's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as need for pain.

ii. On or about June 1, 2011, at 1941 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient ML. Respondent charted the administration of 50 mcg of the medication but failed to chart the wastage or otherwise account for the remaining 50 mcg of the medication.

iii. On or about June 1, 2011, at 2117 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient ML. Respondent charted the

[1] Patients are identified by letters in order to preserve patient confidentiality. The medical record numbers of these patients will be disclosed pursuant to a request for discovery.

[2] Omnicell is a password-enabled system for the automated dispensing and management of medications at the point of use in hospital settings.

administration of 50 mcg of the medication but failed to chart the wastage or otherwise account for the remaining 50 mcg of the medication.

iv. On or about June 3, 2011, at 0336 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient ML. Respondent charted the wastage of 50 mcg of the medication but failed to chart the administration of or otherwise account for the remaining 50 mcg of the medication.

c. PATIENT YH

i. On or about June 2, 2011, Patient YH's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as need for pain.

ii. On or about June 11, 2011, at 0325 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient YH. At 0345 hours, Respondent charted the wastage of 50 mcg of the medication. At 0400 hours, Respondent charted the administration of 25 mcg of the medication. Respondent failed to chart or otherwise account for the remaining 25 mcg of the medication.

d. PATIENT SJ

i. On or about June 19, 2011, Patient SJ's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as need for pain.

ii. On or about June 19, 2011, at 1259 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient SJ. Respondent charted the administration of 25 mcg of the medication but failed to chart the wastage or otherwise account for the remaining 75 mcg of the medication.

e. PATIENT VM

i. On or about June 20, 2011, Patient VM's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as need for pain.

ii. On or about June 20, 2011, at 0510 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient VM. Respondent charted the wastage of 50 mcg of the medication but failed to chart the administration or otherwise account for the remaining 50 mcg of the medication.

iii. On or about June 20, 2011, Patient VM's physician ordered Lorazepam 1 mg every hour as need for pain.

iv. On or about June 20, 2011, at 0510 hours, Respondent removed Lorazepam 2 mg from the Omnicell system to administer to Patient VM. Respondent failed to chart or otherwise account for 2 mg of the medication.

f. PATIENT NB

i. On or about June 29, 2011, Patient NB's physician ordered Oxycodone 2.5 mg every 4 hours as needed for severe pain.

ii. On or about June 30, 2011, at 2240 hours, Respondent removed Oxycodone 5 mg from the Omnicell system to administer to Patient NB. Respondent charted the wastage of 2.5 mg of the medication but failed to chart the administration or otherwise account for the remaining 2.5 mg of the medication.

iii. On or about June 30, 2011, Patient NB's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as need for pain.

iv. On or about July 1, 2011, at 0617 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient NB. Respondent charted the wastage of 50 mcg of the medication but failed to chart the administration or otherwise account for the remaining 50 mcg of the medication.

g. PATIENT PS

i. On or about June 27, 2011, Patient PS's physician ordered Fentanyl 25-50 mcg Intravenous every 15 minutes as need for pain.

ii. On or about June 29, 2011, at 0605 hours, Respondent removed Fentanyl 100 mcg from the Omnicell system to administer to Patient PS. Respondent failed to chart or otherwise account for 100 mcg of the medication.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

22. Respondent's registered nurse license is subject to discipline under Code section 2761, subdivision (a), for unprofessional conduct, as defined by Code section 2762, subdivision (b), in that while employed as a registered nurse at San Francisco General Hospital located in San Francisco, California, he committed acts of gross negligence by failing to properly chart the administration of controlled substances to patients, chart wastage, administration, or otherwise account for medication, as set forth more particularly in paragraphs 20 and 21, above.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Obtaining/Possessing Controlled Substance/ Dangerous Drugs)

23. Respondent's registered nurse license is subject to discipline under Code section 2761, subdivision (a), for unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while employed as a registered nurse at San Francisco General Hospital located in San Francisco, California, he committed the following acts, as set forth in paragraphs 20 and 21, above:

a. Respondent unlawfully obtained and possessed the following controlled substances in violation of Code section 4060: Fentanyl, Lorazepam, and Oxycodone.

b. Respondent unlawfully obtained and possessed the following dangerous drugs: Fentanyl, Lorazepam, and Oxycodone.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Falsify or Make Incorrect or Inconsistent Entries in Records)

24. Respondent's registered nurse license is subject to discipline under Code section 2761, subdivision (a), for unprofessional conduct, as defined by Code section 2762, subdivision (e), and Health and Safety Code section 11190, in that while employed as a registered nurse at San Francisco General Hospital located in San Francisco, California, he made false, grossly incorrect, and/or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and dangerous drugs as set forth in paragraphs 20 and 21, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 780566, issued to Tommie Braden;

2. Ordering Tommie Braden to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: December 5, 2012

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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